



PATIENT INFORMATION

Date
Patient's name
Address
Home Phone
Whom may we thank for referring you to our office?
School
Children/Sibling: Name
Name
Friends seen in our office

RESPONSIBLE PARTY INFORMATION

Self/Parent/Guardian
Residence
Mailing Address
How long at this address?
Cell/Other Phone
Previous Address (if less than 3 years)
SSN
Employer
Marital Status: Single
Spouse/Parent/Guardian/Other
Residence
Mailing Address
How long at this address?
Cell/Other Phone
Previous Address (if less than 3 years)
SSN
Employer
Marital Status: Single
Person financially responsible for this account:

DENTAL INSURANCE INFORMATION

Insured's Name
Birthday



Employer name and address

\_\_\_\_\_

Insured's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ID# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please complete the following information below:

Insured's Name \_\_\_\_\_ Birthday \_\_\_\_\_

Employer name and address \_\_\_\_\_

Insured's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ID# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY INFORMATION**

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

The office reserves the right to verify the credit status of potential patients seeking payment terms

Signature: Self/Spouse/Parent/Guardian/Other \_\_\_\_\_ Date: \_\_\_\_\_

Updates (Date & Initial) \_\_\_\_\_

Updates (Date & Initial) \_\_\_\_\_

Updates (Date & Initial) \_\_\_\_\_



Patient Name \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (if Yes, please fill in details)

- Yes No Are you taking any medications? \_\_\_\_\_
- Yes No Are you allergic to any medication? \_\_\_\_\_
- Yes No Do you have a history of a major illness? \_\_\_\_\_
- Yes No Have you had any operations? \_\_\_\_\_
- Yes No Have you ever been involved in a serious accident? \_\_\_\_\_
- Yes No Have you seen a physician in the last 12 months? Why? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have

- |                              |                 |                          |                       |              |  |
|------------------------------|-----------------|--------------------------|-----------------------|--------------|--|
| Abnormal bleeding/Hemophilia | Diabetes        | Hepatitis/Liver problems | Pneumonia             | Anemia       |  |
| Dizziness                    | Herpes          | Prolonged Bleeding       | Arthritis             | Epilepsy     |  |
| High Blood Pressure          | Radiation/Chemo | Asthma or Hay Fever      | GI Disorders HIV/AIDS |              |  |
| Rheumatic Fever              | Bone Disorders  | Heart Problems           | Kidney Problems       | Tuberculosis |  |
| Congenital Heart Defect      | Heart Murmur    | Nervous Disorders        | Tumor or Cancer       |              |  |

Any other medical conditions, sensory issues or other special needs that you feel we should be aware of \_\_\_\_\_

**DENTAL HISTORY**

Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

- Yes No Are you presently in any dental pain? \_\_\_\_\_
- Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_
- Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_
- Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_
- Yes No Is any part of your mouth sensitive to pressure or temperature? Where? \_\_\_\_\_
- Yes No Do your gums bleed when you brush? \_\_\_\_\_
- Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_
- Yes No Are you a mouth breather? \_\_\_\_\_
- Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_
- Yes No What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_
- Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_
- Yes No How did they feel about the result? \_\_\_\_\_
- Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning? \_\_\_\_\_
- Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_
- Yes No Are you aware of clenching or grinding your teeth? \_\_\_\_\_
- Yes No Do you have "tension" headaches? \_\_\_\_\_
- Yes No Are you aware that some appointments will be during school/work hours? \_\_\_\_\_

Female Patients only:

- Yes No Are you pregnant? \_\_\_\_\_
- Yes No Has menstruation started? \_\_\_\_\_

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Albert Eng or Dr. Trent Nestman to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

**PRIVACY POLICY**



**This policy describes how medical/dental and how you can get access to this information.**

**information about you may be used and disclosed Please read it carefully.**

We understand that the privacy of your personal information is important to you. As your orthodontic office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (303) 498-0351.

#### **Information We Collect About You**

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize, such as: other dentists and specialists, imaging facilities, laboratories, and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect dental information regarding diagnosis, treatment plans, progress and any test results or films.

#### **How Your Information Is Used**

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine health care operations. This means we may send your information to other dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. This includes electronic submission of your information for insurance claim purposes. This also includes contact with you and your family to provide appointment reminders or information about treatment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. Nestman & Eng Orthodontics does not sell patient information to any third party. In certain cases of public health interest we may be required to disclose certain information to local, state, or national health organizations or government agencies.

#### **Safeguarding Your Personal and Health Information**

We are required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Nestman & Eng Orthodontics maintains physical, electronic, and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. A complaint in no way will influence your course of treatment with our office.

#### **Changes to Our Privacy Policy**

All new patients will review a copy of our privacy policy. Nestman & Eng Orthodontics occasionally reviews the privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

#### **Right to Restrict Use of Information**

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

#### **Patient Acknowledgement**

I have reviewed Nestman & Eng Orthodontics' Privacy Policy and understand that my diagnostic records and my name may be used for educational and promotional purposes.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_